FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022897

Facility Name: KANKAKEE TERRACE

Address: 100 BELLE AIRE (Number) BOURBONNAIS (City) 60914 (Zip Code)

County: KANKAKEE

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2883311

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	49,388	785	1,064	51,237	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,388	785	1,064	51,237	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.15%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,789	14,955	7,425	297,169		297,169		297,169			1
2	Food Purchase		202,181		202,181		202,181	(491)	201,690			2
3	Housekeeping	211,048	23,104		234,152		234,152		234,152			3
4	Laundry	85,084	11,316	3,994	100,394		100,394	1,113	101,507			4
5	Heat and Other Utilities			124,841	124,841		124,841	312	125,153			5
6	Maintenance	78,947	32,066	29,479	140,492		140,492	8,969	149,461			6
7	Other (specify):*			5,917	5,917		5,917	67	5,984			7
8	**TOTAL General Services**	649,868	283,622	171,656	1,105,146		1,105,146	9,970	1,115,116			8
	B. Health Care and Programs											
9	Medical Director			2,750	2,750		2,750		2,750			9
10	Nursing and Medical Records	1,274,283	57,492	24,923	1,356,698		1,356,698		1,356,698			10
10a	Therapy	43,505		292	43,797		43,797		43,797			10a
11	Activities	79,723	6,830	1,310	87,863		87,863		87,863			11
12	Social Services	9,070		999	10,069		10,069		10,069			12
13	CNA Training											13
14	Program Transportation			100	100		100		100			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,406,581	64,322	30,374	1,501,277		1,501,277		1,501,277			16
	C. General Administration											
17	Administrative	84,390		452,222	536,612		536,612	(423,761)	112,851			17
18	Directors Fees											18
19	Professional Services			34,586	34,586		34,586	8,384	42,970			19
20	Dues, Fees, Subscriptions & Promotions			11,348	11,348		11,348	(2,561)	8,787			20
21	Clerical & General Office Expenses	79,787	23,245	91,372	194,404		194,404	(73,369)	121,035			21
22	Employee Benefits & Payroll Taxes			356,770	356,770		356,770		356,770			22
23	Inservice Training & Education			608	608		608	22	630			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			29,593	29,593		29,593	438	30,031			25
26	Insurance-Prop.Liab.Malpractice			55,727	55,727		55,727	2,101	57,828			26
27	Other (specify):*			52,260	52,260		52,260	(46,555)	5,705			27
28	**TOTAL General Administration**	164,177	23,245	1,084,486	1,271,908		1,271,908	(535,301)	736,607			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,220,626	371,189	1,286,516	3,878,331		3,878,331	(525,331)	3,353,000			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: KANKAKEE TERRACE **#0022897** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,425	
	REPAIRS & MAINTENANCE		0	
			0	7,425
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,994	
			0	3,994
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		46,627	
	ELECTRICITY		38,250	
	WATER		33,413	
	CABLE TV - LOBBY		6,551	
			0	124,841
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,335	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		16,691	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,617	
	FIRE SERVICE		6,836	
			0	
			0	
			0	29,479
7	**OTHER**			
	SCAVENGER		4,271	
	SECURITY SERVICE		1,646	5,917
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,750	2,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		12,729	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,600	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	100	
	PHARMACY CONSULTANT	XVIII B 39-2	4,894	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,600	
			0	24,923
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	292	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	292
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,310	
			0	1,310
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	999	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	999
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number KANKAKEE TERRACE **#0022897** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		100	100
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	452,222	452,222
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,404	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	21,182	
			0	34,586
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	84	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,170	
	LICENSES & PERMITS	XIX F	750	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,090	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	450	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,804	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	11,348
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		792	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		74,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	180	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,700	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		700	91,372

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	165,923	
	UNEMPLOYMENT COMPENSATION	XIX D	22,273	
	WORKERS COMPENSATION INSURANCI	XIX D	63,394	
	HOSPITALIZATION INSURANCE	XIX D	87,006	
	EMPLOYEE BENEFITS - OTHER	XIX D	765	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	17,409	
		XIX D		356,770
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		608	608
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		29,593	29,593
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		55,727	55,727
27	**OTHER**			
	BAD DEBTS	VI 24	52,260	
				52,260

GRAND TOTAL COLUMN 3 OTHER 1,286,516

KANKAKEE TERRACE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	202,181	PATIENT MEALS	153711
LESS SALES TAX	(491)	ADD EMPLOYEE MEALS	0
NET FOOD	201,690	TOTAL MEALS/YEAR	153711
TOTAL PATIENT CENSUS	51,237	NET FOOD	201690
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	153711
TOTAL PATIENT MEALS	153711	COST PER MEAL	1.31
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number KANKAKEE TERRACE #0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			57,527	57,527		57,527	10,651	68,178			30
31	Amortization of Pre-Op. & Org.			696	696		696		696			31
32	Interest			166,151	166,151		166,151	(61,659)	104,492			32
33	Real Estate Taxes			46,253	46,253		46,253	1,536	47,789			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,041	52,041		52,041	4,167	56,208			35
36	Other (specify):* **RENT OFFICE**			11,232	11,232		11,232	(11,232)				36
37	**TOTAL Ownership**			333,900	333,900		333,900	(56,537)	277,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,935	79,935		79,935		79,935			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,220,626	371,189	1,700,351	4,292,166		4,292,166	(581,868)	3,710,298			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,457	30		9
10	Interest and Other Investment Income	(63,297)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(491)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(450)	20		17
18	Fines and Penalties	(180)	21		18
19	Entertainment		20		19
20	Contributions	(1,804)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(558)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,260)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,090)	20		28
29	Other-Attach Schedule SEE PAGE 5-A	(17,823)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (128,496)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(453,372)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (453,372)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (581,868)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

KANKAKEE TERRACE

ID# 0022897

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 6,877	6	1
2	STAFF DEVELOPMENT	(700)	21	2
3	MARKETING SALARY	(24,000)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(17,823)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KANKAKEE TERRACE # 0022897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(491)	0	0	0	0	0	0	0	0	0	0	(491)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,113	0	0	0	0	0	0	0	0	1,113	4
5	Heat and Other Utilities	0	0	0	312	0	0	0	0	0	0	0	312	5
6	Maintenance	6,877	0	1,473	619	0	0	0	0	0	0	0	8,969	6
7	Other (specify):*	0	0	33	34	0	0	0	0	0	0	0	67	7
8	**TOTAL General Services**	6,386	0	2,619	965	0	0	0	0	0	0	0	9,970	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(429,711)	5,950	0	0	0	0	0	0	0	0	(423,761)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(558)	382	8,509	51	0	0	0	0	0	0	0	8,384	19
20	Fees, Subscriptions & Promotions	(3,344)	0	783	0	0	0	0	0	0	0	0	(2,561)	20
21	Clerical & General Office Expenses	(24,880)	5,558	(54,296)	249	0	0	0	0	0	0	0	(73,369)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	22	0	0	0	0	0	0	0	0	22	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	63	375	0	0	0	0	0	0	0	0	438	25
26	Insurance-Prop.Liab.Malpractice	0	157	1,756	188	0	0	0	0	0	0	0	2,101	26
27	Other (specify):*	(52,260)	1,704	4,001	0	0	0	0	0	0	0	0	(46,555)	27
28	**TOTAL General Administration**	(81,042)	(421,847)	(32,900)	488	0	0	0	0	0	0	0	(535,301)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,656)	(421,847)	(30,281)	1,453	0	0	0	0	0	0	0	(525,331)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KANKAKEE TERRACE # 0022897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,457	0	206	988	0	0	0	0	0	0	0	10,651	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(63,297)	0	0	1,638	0	0	0	0	0	0	0	(61,659)	32
33	Real Estate Taxes	0	0	0	1,536	0	0	0	0	0	0	0	1,536	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	319	3,628	220	0	0	0	0	0	0	0	4,167	35
36	Other (specify):*	0	0	0	(11,232)	0	0	0	0	0	0	0	(11,232)	36
37	**TOTAL Ownership**	(53,840)	319	3,834	(6,850)	0	0	0	0	0	0	0	(56,537)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,496)	(421,528)	(26,447)	(5,397)	0	0	0	0	0	0	0	(581,868)	45

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 440,222	EMI ENTERPRISES	100.00%	$	$ (440,222)	1
2	V								2
3	V	17	OFFICERS SALARY				10,511	10,511	3
4	V	19	ACCOUNTING FEES				382	382	4
5	V	21	OFFICE EXPENSE				5,558	5,558	5
6	V	25	TRANSPORTATION				63	63	6
7	V	26	INSURANCE				157	157	7
8	V	27	EMPLOYEE BENEFITS				1,704	1,704	8
9	V	35	AUTO LEASE				319	319	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 440,222			$ 18,694	$ * (421,528)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	$ 74,000	EKS MANAGEMENT	100.00%	$	$ (74,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				1,113	1,113	17
18	V	6	PAINTERS SALARIES				1,473	1,473	18
19	V	7	SCAVENGER				33	33	19
20	V	17	CFO SALARY				5,950	5,950	20
21	V	19	PROFESSIONAL FEES				8,509	8,509	21
22	V	20	WANT ADS/BACKGR CKS				783	783	22
23	V	21	OFFICE EXPENSE				19,704	19,704	23
24	V	23	SEMINARS				22	22	24
25	V	25	TRANSPORTATION				375	375	25
26	V	26	INSURANCE				1,756	1,756	26
27	V	27	EMPLOYEE BENEFITS				4,001	4,001	27
28	V	30	DERPECIATION (SL)				206	206	28
29	V	35	EQUIPMENT RENT				3,628	3,628	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,000			$ 47,553	$ * (26,447)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 11,232	IME REALTY		$	$ (11,232)	15
16	V								16
17	V								17
18	V	5	UTILITIES				312	312	18
19	V	6	REPAIR & MAINTENANCE				619	619	19
20	V	7	ALARM SERVICE				34	34	20
21	V	19	PROFESSIONAL FEES				51	51	21
22	V	21	OFFICE EXPENSE				249	249	22
23	V	26	INSURANCE				188	188	23
24	V	30	DEPRECIATION				988	988	24
25	V	32	INTEREST				1,638	1,638	25
26	V	33	RE TAX				1,536	1,536	26
27	V	35	STORAGE FEES				220	220	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,232			$ 5,835	$ * (5,397)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION					SALARY	$ 10,511	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	5,950	17-7	2
3	PHILIP ESFORMES							MGMT. FEE	12,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,461		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	901,761	15	$ 185,000	$ 185,000	51,237	$ 10,511	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725		51,237	382	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	76,576	51,237	5,558	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114		51,237	63	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768		51,237	157	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997		51,237	1,704	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617		51,237	319	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 329,044	$ 261,576		$ 18,694	25

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	$ 19,581	$ 19,441	51,237	$ 1,113	1
2	6	PAINTERS SALARIES	PATIENT DAYS	901,761	15	25,925	25,925	51,237	1,473	2
3	7	SCAVENGER	PATIENT DAYS	901,761	15	573		51,237	33	3
4	17	CFO SALARY	PATIENT DAYS	901,761	15	104,714	104,714	51,237	5,950	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	119,638	51,237	8,509	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	901,761	15	13,787		51,237	783	6
7	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	51,237	19,704	7
8	23	SEMINARS	PATIENT DAYS	901,761	15	380		51,237	22	8
9	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593		51,237	375	9
10	26	INSURANCE	PATIENT DAYS	901,761	15	30,900		51,237	1,756	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423		51,237	4,001	11
12	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617		51,237	206	12
13	35	EQUIPMENT RENT	PATIENT DAYS	901,761	15	63,848		51,237	3,628	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 836,892	$ 518,647		$ 47,553	25

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	346,361	17	$ 9,618	$	11,232	$ 312	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	346,361	17	19,083		11,232	619	2
3	7	ALARM SERVICE	RENTAL INCOME	346,361	17	1,056		11,232	34	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	346,361	17	1,575		11,232	51	4
5	21	OFFICE EXPENSE	RENTAL INCOME	346,361	17	7,666		11,232	249	5
6	26	INSURANCE	RENTAL INCOME	346,361	17	5,806		11,232	188	6
7	30	DEPRECIATION	RENTAL INCOME	346,361	17	30,446		11,232	988	7
8	32	INTEREST	RENTAL INCOME	346,361	17	50,514		11,232	1,638	8
9	33	RE TAX	RENTAL INCOME	346,361	17	47,364		11,232	1,536	9
10	35	STORAGE FEES	RENTAL INCOME	346,361	17	6,785		11,232	220	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 179,913	$		$ 5,835	25

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE BANK		X	MORTGAGE	$15,553.00	11/01/01	$ 2,283,583	$ 2,021,199		PRIME+	$ 131,675	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL							11,781	6
7	LASALLE BANK		X	NOTE PAYABLE				317,911			22,695	7
8	RELATED PARTY	X									1,638	8
9	TOTAL Facility Related				$15,553.00		$ 2,283,583	$ 2,339,110			$ 167,789	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,283,583	$ 2,339,110			$ 167,789	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number KANKAKEE TERRACE # 0022897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	45,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	45,253	2
3. Under or (over) accrual (line 2 minus line 1).	$	53	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	46,253	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	45,914	8
2001	46,051	9
2002	45,875	10
2003	44,746	11
2004	45,253	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME KANKAKEE TERRACE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0022897

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-20-107-040	NURSING HOME	$	$
2.	17-09-20-107-041	NURSING HOME	$ 45,252.84	$ 45,252.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,252.84	$ 45,252.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,663 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	118		1976	1972	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5	28			1998	981,637	25,170	39	25,170		189,840	5
6											6
7											7
8	IME REALTY				33,594	949		949			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1978	8,584		10			8,584	9
10	BUILDING IMPROVEMENTS			1981	8,060		15			8,060	10
11	BUILDING IMPROVEMENTS			1987	51,503	1,635	31.5	1,635		29,362	11
12	BUILDING IMPROVEMENTS			1988	7,400	235	10		(235)	7,400	12
13	BUILDING IMPROVEMENTS			1988	17,500	556	15	481	(75)	18,462	13
14	BUILDING IMPROVEMENTS			1990	27,632	877	20	1,382	505	21,421	14
15	BUILDING IMPROVEMENTS			1991	12,763	406	20	638	232	9,251	15
16	BUILDING IMPROVEMENTS			1992	36,068	1,145	31.5	1,145		15,317	16
17	BUILDING IMPROVEMENTS			1993	40,178	1,253	31.5	1,276	23	16,158	17
18	BUILDING IMPROVEMENTS			1994	18,233	467	39	467		5,442	18
19	CARPET			1996	8,028	206	39	206		1,931	19
20	SHADE STRUCTURE			1997	2,200	57	39	57		484	20
21	CONCRETE SLAB			1997	667	17	39	17		148	21
22	NURSE STATION			1998	4,950	127	39	127		1,049	22
23	ROOFTOP AC			1998	2,031	52	39	52		390	23
24	PARKING LOT			1999	18,460	1,231	15	1,231		8,001	24
25	ROOFTOP AC			1999	6,716	172	39	172		1,160	25
26	DOORS			1999	2,151	55	39	55		342	26
27	CARPET			1999	14,114	362	39	362		2,217	27
28	DRAPERIES & RODS/REPLACE SHINGLES			2000	7,865	1,124	20	393	(731)	2,162	28
29	LANDSCAPE RENOVATION			2000	6,700	447	15	447		2,458	29
30	VINYL/CERAMIC TILE			2000	1,941	71	27.5	71		411	30
31	CARPET & FLOOR TILE			2001	16,962	617	20	848	231	4,240	31
32	CONTROL VALVE REPL			2002	2,849	104	27.5	104		416	32
33	NEW FLOOR - LAUNDRY			2003	2,874	104	27.5	104		256	33
34	ROOF			2003	24,800	902	27.5	902		2,217	34
35	FURNACES			2003	23,436	852	27.5	852		2,095	35
36	GUTTERS			2003	6,231	227	27.5	227		558	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL FURNACES	2003	$ 10,400	$ 378	27.5	$ 378	$	$ 929	37
38	ROOF REPAIR/ROOFTOP AIR-CONDITIONER	2004	5,458	199	27.5	199		290	38
39	SMOKE DAMPERS	2004	2,625	95	27.5	95		139	39
40	FLOOR TILES	2004	2,882	105	27.5	105		153	40
41	ROOF EXHAUSTER	2005	1,958	32	27.5	32		32	41
42	FLOOR TILES	2005	9,700	161	27.5	161		161	42
43	SIDEWALK	2005	7,575	253	15	505	252	505	43
44	BACKDOOR	2005	3,250	54	27.5	54		54	44
45	CHEMICAL FIRE SYS	2005	1,742	30	27.5	30		30	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,674,717	$ 40,727		$ 40,929	$ 202	$ 1,595,125	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 271,253	$ 16,164	$ 26,608	$ 10,444	10	$ 165,969	71
72	Current Year Purchases	7,924	1,585	396	(1,189)	10	396	72
73	Fully Depreciated Assets	333,973					333,973	73
74	RELATED PARTY		245	245				74
75	TOTALS	$ 613,150	$ 17,994	$ 27,249	$ 9,255		$ 500,338	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,387,867	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,721	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,178	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,457	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,095,463	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,900 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SEE SCHEDULE ATTACHED		$	$ 42,141	17
18					18
19					19
20					20
21	TOTAL		$	$ 42,141	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number KANKAKEE TERRACE # 0022897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,351	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 36,000)	935,192		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,622		6
7	Other Prepaid Expenses	27,223		7
8	Accounts Receivable (owners or related parties)	362,951		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,420,339	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	983,982		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	1,408,123		15
16	Equipment, at Historical Cost	613,150		16
17	Accumulated Depreciation (book methods)	(2,167,377)		17
18	Deferred Charges	14,282		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,185,160	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,605,499	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 578,049	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	53,000		29
30	Accrued Salaries Payable	71,977		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,003		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,200		32
33	Accrued Interest Payable	14,938		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 791,167	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	317,911		39
40	Mortgage Payable	2,021,199		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,339,110	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,130,277	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 475,222	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,605,499	$	48

***(See instructions.)**

Facility Name & ID Number KANKAKEE TERRACE # 0022897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 479,426	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 479,426	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	743,396	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(747,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (4,204)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 475,222	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	1 Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,972,265	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,972,265	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	63,297	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 63,297	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,035,562	30

	2 Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,105,146	31
32	Health Care	1,501,277	32
33	General Administration	1,271,908	33
	B. Capital Expense		
34	Ownership	333,900	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,292,166	40
41	**Income before Income Taxes (line 30 minus line 40)****	743,396	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 743,396	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,084	2,312	$ 58,764	$ 25.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,863	8,683	188,866	21.75	3
4	Licensed Practical Nurses	7,700	8,541	159,610	18.69	4
5	CNAs & Orderlies	51,061	59,394	652,978	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,552	3,403	43,505	12.78	8
9	Activity Director					9
10	Activity Assistants	8,137	8,910	79,723	8.95	10
11	Social Service Workers	1,016	1,063	9,070	8.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,998	25,259	274,789	10.88	15
16	Dishwashers					16
17	Maintenance Workers	6,240	6,327	78,947	12.48	17
18	Housekeepers	20,390	24,238	211,048	8.71	18
19	Laundry	5,762	6,789	85,084	12.53	19
20	Administrator	2,544	2,637	80,640	30.58	20
21	Assistant Administrator	143	143	3,750	26.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,157	11,606	79,787	6.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	14,373	15,338	177,000	11.54	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	982	1,132	13,800	12.19	31
32	Other Health C: QUALITY ASSUR	2,080	2,080	23,265	11.19	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,082	187,855	$ 2,220,626 *	$ 11.82	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,425	1-3	35
36	Medical Director		2,750	9-3	36
37	Medical Records Consultant		100	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,894	10-3	39
40	Physical Therapy Consultant		292	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		1,310	11-3	44
45	Social Service Consultant		999	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,770		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDY LEBEAU	ADMIN	0	$ 80,640
KIMBERLY STEELE	ASST ADMIN	0	3,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,390

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 440,222
P. ESFORMES	12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 452,222
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		34,586
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,586

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,394
Unemployment Compensation Insurance	22,273
FICA Taxes	165,923
Employee Health Insurance	87,006
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	765
EMPLOYEE PHYSICAL EXAMS	0
UNION PENSION	17,409
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,770

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	84
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,090
TRUST/FRANCHISE/CONTRIB/ETC	2,254
LICENSES & PERMITS	750
DUES & SUBSCRIPTIONS	7,170
MGMT CO ALLOCATION	783
TRUST/FRANCHISE/CONTRIB/ETC	(2,254)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(1,090)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,787

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2003	$ 11,721	3YRS	$	$ 1,954	$ 3,907	$ 3,907	$ 1,953	$	$	$	$
2	PAINT/DECORATING	2004	8,909	3YRS			1,485	2,970	2,970	1,484			
3													
4													
5													
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17													
18													
19													
20	TOTALS		$ 20,630		$	$ 1,954	$ 5,392	$ 6,877	$ 4,923	$ 1,484	$	$	$

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL OF LONG TERM CARE $6452**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **145** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees